CITY OF TUCSON
Employee Insurance Benefits Office

MEDICAL OPT-OUT INCENTIVE PROGRAM

(For employees who have medical coverage that is not through any City of Tucson medical plan)

Name: _____

Employee ID number or SSN: _____

I am waiving medical coverage provided by the City of Tucson. I have other medical coverage and have attached proof of that coverage – insurance card or letter from the company providing coverage. I understand that I will receive the incentive for medical coverage waiver of $80.00 per month ($36.92 per pay period) and that this payment is subject to federal and state income tax withholding and FICA taxes. At any time, upon request by the City, I will provide proof of other medical coverage.

_____ _____

Signature Date

_____

Email address

_____

Phone
